MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

DIVISION OF COMMUNITY HEALTH

Section for Community Health Systems and Support

Healthy Communities and Schools Unit

MCH PROGRAM GUIDANCE

FOR

FFY 2005 Maternal and Child Health Services Contract

Effective Dates: October 1, 2004 to September 30, 2005

PROGRAM GUIDANCE
For Establishing Outcome-Based
FFY 2005 Maternal and Child Health Services Contracts

Table of Content

PROGRAM GUIDANCE

For Establishing Outcome-Based

FFY 2005 Maternal and Child Health Services Contracts

Section 1: Background

A. Introduction

This document begins with a summary of the design of the MCH program contract and includes an invitation for proposals for funding from local public health agencies. The FFY 2005 contract continues as a fixed-price outcome-based contract.

Prior to the outcome-based contract, the MCH contract focused on delivery of MCH related activities and how the money is spent. The contract was not focused on health outcome improvement or whether the dollars spent achieved outcomes worthy of the expenditure. As long as the activities followed the work plan and the expenditures followed the budget, the money continued to flow. Health outcomes were not related to money spent.

The Missouri Department of Health and Senior Services (Department) made the decision to change how it does business. There is a double focus in the shift. The first is a general movement away from contracts based on cost-based reimbursement and toward performance-based or outcome-based contracting.

The second, and primary, focus is to build and maintain a strong system of care to provide core public health functions. To be strong, the system must have six basic components. Those components include the capacity to: 1.) Identify problems and solutions; 2.) Continually assess and monitor identified problems; 3.) Plan and maintain referral systems; 4.) Assure people are in place who can effectively address needs and assure that regulations are followed; 5.) Provide education in order to identify problems and solutions; and 6.) Evaluate how the system is working and use the evaluation information to improve the system.

The core public health functions are central to developing and maintaining a system to coordinate services to meet the needs of a community. No matter whether an issue deals with communicable disease, safety, teen pregnancy or health care for children, when the system is in place, issues will be recognized and dealt with appropriately. Service coordination is ‘the glue’ that makes the system work seamlessly.

Maternal and child health is just one part of this public health system. This contracting method, “fixed price outcomes-based,” proposes to establish a MCH service coordination system, partially funded through Title V Block Grant dollars. The local public health agency (LPHA) will contract to build and maintain this system within their county or city, using a contract that includes certain outcomes.

The advantages of this contract type include more flexibility in using funds, far less paperwork, and more local decision-making. One of the primary reasons for beginning this change in contracting method is to support the LPHA in their assurance role through Title V Block Grant funding.

Section 1: Background *(Continued)*

B. Appreciation

This contract design was reached after several months of discussion with numerous Department staff and representatives from LPHAs. Special thanks goes to representatives from the Director's Advisory Council on Local Health and representatives from Department for the many hours given to this effort to discuss and comment on this design.-

C. History

This change in doing business is happening across the nation, not just in public health, but also in all facets of government. As public health dollars become more scarce, it is increasingly important that each dollar be used prudently. Several factors contribute to and support this change in the MCH contract.

GPRA: The federal Government Performance and Results Act, known as GPRA, took effect, government-wide, in 1997. To meet the challenges, all levels of government need to maintain high-performing organizations to focus on performance management and to use effective methods. GPRA is a tool Congress created to focus the budget process on results, rather than merely good intentions.

The GPRA structure of strategic plans, annual performance plans and annual performance reports is a framework for integrating planning, budgeting and accountability processes. This calls for more efficient organizations at all levels of government. To meet the challenges, all levels of government will need to maintain high-performing organizations.

Healthy People 2010: Along with GPRA and the focus on outcomes, the Department is committed to the Healthy People 2010 goals and objectives. Achievement of objectives is dependent on health agencies in all levels of government and non-governmental organizations to assess objective progress.

HRSA: The Health Resources and Services Administration (HRSA), a lead Federal agency in promoting improvements to the Nation's health, has one primary goal. The goal is access to care for everyone. HRSA has four strategies to support this goal: 1.) Eliminate barriers to care 2.) Eliminate health disparities, 3.) Assure quality of care, and 4.) Improve public health and health care systems. The work is carried out through HRSA programs that provide funding to the States.

The Maternal Child Health Bureau (MCHB) Block Grant Program is one of their programs. The MCHB began using performance measures in 1997 to orchestrate their partnership with the States.

Missouri's Experience: Between 1999 and 2001, the Department has structured the MCH contract around the MCH Block Grant 1997 performance measures. Contracts were based on local activities to support selected performance measures. Budgets were developed, activities were completed, money was spent and expenses were billed to the Department. Within those cost-reimbursement contracts, the focus has been on whether the pre-agreed upon activities were completed, whether the money was spent as defined in the contract, and whether all the money was spent. This method of contracting created an administrative burden for everyone involved. Despite all of the effort involved the health indicators for Missouri are failing to improve significantly. The next logical step for Missouri was to re-examine how we are addressing the MCH needs.

Section 1: Background *(Continued)*

Next Steps: The Department needed to move toward more functional performance measure outcomes. The new design of the contract for the MCH Program is focused on creating a stronger MCH public health system in order to achieve improved outcomes. To make this design operational, the MCH contract is now a fixed-price and outcomes-based contract.

During the development of this contract model, two questions consistently occurred: "What will the effect of the fixed-price outcomes-based contract be on public health in Missouri?" and " How do we best go about creating an MCH contract for Missouri?" Nationally, cookie cutter models for "how-to-do-it" do not exist.

To answer these questions, the Director's Advisory Council on Local Health selected representatives from each district to partner with the Department in an advisory capacity. Department staff gathered information from various sources to help design the best model for Missouri. Numerous meetings occurred over a one-year planning period to design the MCH system.

Philosophy Behind The MCH Service Coordination System: Improved health outcomes can best occur when the community works together to assure that women, children, and families have access to needed personal and population-based health services. To assure a strong responsive MCH health care system state-wide, efforts need to be focused at three levels: when working with just one individual or family, when looking at the needs of the entire population, and when addressing the public health infrastructure system level.

Certain mechanisms are needed to take care of all three levels: sharing information about health care issues with the public; assuring accountability and providing population-based preventive services; and tracking and follow-up to help secure adequate health care for women and their families.

The MCH service coordination system has six components. These components: identification, assessment, referral, assurance, education and evaluation support this philosophy and also support the core public health functions.

Service coordination is the key factor required in order to build a strong system that addresses the needs of individuals, the population-base and the infrastructure of the health system.

MCH Ten Essential Services: One of the changes in our national health care system in recent years is the increased attention to integrating health care delivery networks. The core public health functions of assessment, policy development and assurance were defined. Along with the core public health functions, essential public health services to improve the health of the entire population have been identified to meet national health objectives.

National MCH leaders defined the elements of public health systems and services that are needed to assure the appropriate focus on the needs of women, children and youth. To enhance the public sector capacity to respond to the unique needs of this population, essential MCH services were defined.

The framework of the essential MCH functions makes operational the core public functions in the context of maternal and child health. It gives local, state, and federal MCH staff a tool that can be used to plan and develop stronger MCH health systems. It is upon this framework that the new MCH contract design is based. Within this philosophy, there is a strong focus on meeting the needs of all children with a special health care need. Service coordination within the MCH system includes addressing children with special health care needs.

Section 2: Terms and Conditions

A. Intent of Invitation For Proposals (IFP)

It is the intent of the Missouri Department of Health and Senior Services (Department) to enter into a contract to establish within each local public health jurisdiction; an integrated multi-tiered (individual,

community and system) service coordination system capable of adapting to address targeted maternal-child health issues.

B. Purpose of the Solicitation

The purpose of the Maternal Child Health (MCH) contract is to provide funding to be used solely to benefit residents of Missouri. Through this contract, the Department and local public health agencies are able to work together to improve the health of Missouri mothers and children through fixed-price outcome-based contracts.

C. Program Structure

The MCH Program operates under the supervision of the Missouri Department of Health and Senior Services, the Division of Community Health, Section for Community Health Systems and Support, Healthy Communities and Schools Unit, and the MCH Program Manager.

The Department implemented the fixed-price outcome-based contract model to reduce the emphasis on process and input, while increasing the focus on outcomes. Outcome-based contracting becomes a tool for quality improvement, performance assessment, and accountability. People and organizations with targets tend to outperform those without them. There are several advantages for shifting to this method of contracting:

Fixed-price outcome-based contracting will minimize centralized management by the funding agency and rigid rules.

- Outcome information can assure funders and the public that investments are producing results.
- Agreement on desired results can facilitate cross-system collaboration on behalf of children and their families.
- Information about results enhances community and agency capacity to judge the effectiveness of their efforts. The community can understand whether their programs are having the desired impact.
- A focus on results clarifies whether allocated resources are adequate to achieve the outcomes expected and may more realistically limit the number of outcomes that can be achieved.
- Accountability, with flexibility, to manage the program.

The intent of the MCH contract design is for LPHAs to be accountable for making progress, and create a way for the LPHAs to have the flexibility to manage their MCH activities and funds to meet their local needs.

To do both of these things, the MCH contracts treat funding in essentially two categories – a guaranteed or “assured” category and a provisional category. These provisional funds represent a flexible funding base that can be positively affected by performance.

Section 2: Terms and Conditions *(Continued)*

D. Letter of Intent

By 5 p.m., on April 30, 2004, the Department must receive a letter stating the LPHA's intent to respond to the Invitation for Proposal, or decision to not submit a proposal. Letters should be prepared on agency letterhead, contain an authorized signature and be submitted either by fax to 573-526-5347, or by personal delivery or mail:

MCH Program Manager
Missouri Department of Health and Senior Services
Family Health
920 Wildwood Drive
P.O. Box 570
Jefferson City, MO 65102-0570

E. Core Elements of the MCH Contract

1.) **Service Coordination:** The Case Management Society of America defines "case management" as, "A collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual's health needs, using communications and available resources to promote quality and improved outcomes." Case management is a term with a more clinical focus, but the definition relates well to the new MCH service coordination system.

Service coordination is the glue that makes the system work well for clients, for provider groups, and for the whole community. Good service coordination may point to needs for infrastructure changes at any level. The service coordination element of the contract includes the following intervention tiers:

Individual-focus: The coordination of needed services when working with an individual or family. Interventions that work to change the knowledge, attitudes, beliefs, practices, skills and behaviors of individuals.

Community-focus: The coordination functions performed to assure that preventive interventions and services are available for the entire MCH population of the jurisdiction. Interventions are focused to changing community norms, community attitudes, community awareness, community practices, and community behaviors. Interventions may be directed at the entire population in a community or sometimes toward target groups within the population.

System-focus: Activities directed at improving and maintaining the health status of all women and children by providing support for infrastructure development and maintenance of comprehensive health systems. Interventions work to change organizations, policies, laws, and power structures. There is less of a focus on the individuals and community, and more focus on the systems that impact health.

2.) **Plan of Work**: Each MCH contractor will develop a proposed plan of work. The document should follow the outline as shown in Appendix A and be prepared using a font size of no smaller than twelve (12). When completed, the plan of work will become part of the MCH contract.

The contract will be one year with the option of two additional one-year renewal periods. To qualify for the renewal option, the Contractor shall supply a plan of work for at least two consecutive years.

Section 2: Terms and Conditions *(Continued)*

The plan of work will address the MCH population needs, and the service coordination system components of identification, assessment, referral, assurance, education and evaluation and the capacity-building outcome for system development based on the MCH Ten Essential Services capacity assessment. The capacity assessment tool based on the MCH Ten Essential Services, may be used to help identify system strengths and weaknesses and guide the planning process for proposed systems improvements. Attention must be given to each system component. Appendix B shows the relationship of the MCH Ten Essential Services to the service coordination system components.

a.) Performance References Spreadsheet: The MCH Performance References spreadsheet, provided to each potential contractor, contains a listing of 18 MCH performance measures drawn from the Department strategic plan, Healthy People 2010 goals and objectives, and state MCH priorities.

For each performance measure, 1999 baseline data is shown for the State and for the County/City. For each performance measure the spreadsheet contains annual target projections through the year 2005 for both the state and jurisdiction.

For the FFY 2005 contract, the plan of work must address a minimum of two and a maximum of four problem areas identified as the targets for intervention in the FFY 2002 MCH contract. The Contractor is cautioned to carefully consider the decision to decrease the number of problem priority areas weighing the inherent contractual obligations and the impact upon the target population. Overall, the Department does not encourage changing identified problem priority areas from year to year. Criteria for selecting problem priority areas to address is as follows:

1. The Contractor may select 2, 3, or 4 of the problem priority areas targeted for intervention in the FFY 2002 MCH contract.
2. The Contractor may substitute a problem priority area that was not targeted for intervention in the FFY 2002 MCH contract for one of the 2 – 4 areas indicated above if compelling evidence exists. Such substitution will be at the discretion of the District Teams.
3. No area identified as " ✔ " under the column heading "County State Variance" may be selected.
4. No area identified as "NA" under the column heading "County State Variance" may be selected in instances where the County rate is better than the State rate.

If the Contractor feels a highlighted MCH problem area is being adequately addressed within the community, the plan of work shall provide evidence to show that other community resources are addressing an identified priority problem as listed on the MCH Performance Reference. The contractor shall explain the current resources committed or potentially available for addressing the priority problem(s) and the contractor's involvement in the plan for addressing the priority problem.

For highlighted MCH problem areas where the county/city baseline data are not statistically significant, the Contractor may request to target another performance measure without having to provide supporting information. This applies only to performance measures with the notation of "N/S" under the column heading "County State Variance."

Section 2: Terms and Conditions *(Continued)*

b.) Other Performance Measures: The Contractor may request to target another MCH performance measure. The Contractor, with the introduction of supportive data/documentation, may negotiate to address additional or alternate MCH problem areas.

Community information, supporting data, and previously described documentation of how target indicators are being addressed must be prepared to support focusing on additional or alternative problem areas.

For other health indicators, that are "at or better than" the State target rate, the Contractor will maintain the rate at the projected state rate for subsequent years.

c.) Target Projections: The five-year target projections on the MCH Performance Reference spreadsheets are calculated for each county/city according to the amount of annual improvement needed in order to meet the 2010 objectives. The target projections are the aiming points in an outcomes-based contract. In no way are the annual target projections to be considered contractual obligations to be met by the Contractor.

Target projections are negotiable during the initial writing of the plan of work. The targets are negotiated in the context of each county/city; no comparison will be made to targets set for other cities or counties.

When negotiations are completed, a District Team member and the Contractor shall sign the Performance Reference spreadsheet. A copy of the Performance References Spreadsheet showing the negotiated target projections shall be attached to the plan of work and will become part of the annual MCH contract.

d.) Description of MCH System: The plan of work must provide a description of the existing MCH system for addressing each problem priority area. The description shall define the Contractor's role, and the role of community partners, in the existing service coordination system at the individual level, the community level and the system level.

The proposed system must describe what will be done to address the problem areas and will improve the system during the contract year. The capacity assessment tool can be used to guide the planning process and development of proposed systems improvements and outcomes. The Contractor shall identify and work with appropriate agencies and community organizations to complete the plan of work.

Those affected by decisions based on performance measures should share in creating and selecting the outcomes. The focus is on building and strengthening systems to provide core public health functions. Contractors that have a detailed plan of steps to be undertaken are most likely to be successful.

e.) Evidence-based Interventions: The Contractor shall use interventions that are evidence-based, field-tested or validated by expert opinion. The Division of Community Health has as a goal that eighty percent (80%) of interventions implemented by its contracts will be evidence-based.

Science contributes to advances in MCH public health practice. To make the most change in health indicators, use of interventions that are known to work is critical. This contract allows us to adapt expert opinion or field tested interventions to create and/or discover interventions that are effective in Missouri.

f.) Outcomes: The Contractor shall include milestones and short-term outcomes in the plan of work. It would be ideal if the contract outcomes could be long-term changes in the health

Section 2: Terms and Conditions *(Continued)*

indicators for the population. However, change in many of the indicators takes several years to accomplish and requires major system changes. Many health indicators would require massive investments, far more than this contract can provide. To meet the challenge of building and strengthening the MCH public health care system, a short-term outcome is much more modest than ultimate health status changes for a population base.

However, the two are linked. The linkage of the 2010 national health goals and the performance indicators for Missouri is the point to which the contract outcomes are leading. Meeting or exceeding the targets set for the performance indicators is the long-term outcome. The work on these complex issues has to be broken down into annual manageable pieces.

- Short-term outcomes for the plan of work must state the behavior change to be achieved in the target population, must be defined in measurable and definable terms, and must be completed within the annual cycle of the contract.
- Milestones for the plan of work must be defined for the contract. The milestones are the critical steps that must be achieved to make a change in the attitude, knowledge and skills in the target population. The attainment of the milestones will lead to meeting the short-term outcomes.

The milestones and short-term outcomes set direction and are a tool for quality improvement, performance assessment and accountability. They are the change measures to make the system work better.

g.) **Timeline**: The contractor shall include a timeline for achieving each milestone and short-term outcome. The contractor and the Department shall negotiate the timeline during the initial writing of the plan of work. The focus is on progress toward meeting outcomes.

h.) **30% Requirement:** In this contract a minimum 30% of the Contractor's efforts must be directed toward children with special health care needs. Efforts directed toward children with special health care needs must be identified in the plan of work with an asterisk. See definition of children with special health care needs in Appendix J.

i.) **Deliverables:** The contract deliverables are the negotiated short-term outcomes.

k.) **Evaluation and Continuous Quality Improvement:** In order to make operations more efficient, more effective and to achieve continuous improvement, methods to evaluate operations are essential. Defining, measuring, understanding and controlling the processes that constitute public health practice are essential elements of the improvement agenda for the public health system in Missouri. It is the expectation of the Division of Community Health that each of its Contractors shall define and support processes that include the systematic collection of information about resources, activities, target population and intended results. Every system supported by MCH Contractors should be continuously redesigned based on evaluation activities to better achieve those intended results.

Each contractor shall develop and implement a written plan for continuous quality improvement.

Refer to Appendix D for a summary of the core elements of the MCH contract.

Section 2: Terms and Conditions *(Continued)*

F. Federal Funding

These monies are made available through the Title V Maternal and Child Health Block Grant of the federal Social Security Act, in anticipation of FFY2005 Maternal and Child Health Block Grant funding being passed by the U. S. Congress and being available by October 1, 2004.

G. Eligibility

The Department of Health and Senior Services is inviting proposals for funding from Missouri local public health agencies. Any Missouri local public health agency is eligible. No proposal may cover an area smaller than a county in size with the exception of Joplin, Independence, Springfield, Kansas City and St. Louis City.

H. Procurement Process

The Department will accept non-competitive proposals from local public health agencies for the FFY 2005 contract period. Proposals shall be submitted in response to this Invitation for Proposals. Completed proposals shall be submitted to the MCH District Nurse Consultant. The initial review and negotiation of the content of the proposal will be conducted by the MCH District Team, which is composed of the MCH District Nurse Consultant and the CHART Community Support Consultant. Fully negotiated and agreed upon proposals shall be submitted to the Department-Central Office for final review. After the initial screening process of the proposal, the Department reserves the right to clarify or verify any component of the proposal that is unclear. Awards shall be made to the Contractor following completion of an approved proposal. See Appendix A for Guidelines and Checklist for Preparing and Submitting Proposals.

For FFY 2005, the Department will <u>not</u> seek competitive proposals. In future years, the Department reserves the right to solicit competitive proposals in any jurisdiction.

I. Negotiation Phase

For a decentralized MCH contract process to be successful, the Department has established a decentralized process to provide technical assistance to LPHAs and to conduct the initial review of the proposals.

MCH District Teams are the initial contact with the LPHA in the development and preliminary negotiation of the contract plan of work. The Department delegates to the District Teams, the initial negotiation of the plan of work between the LPHA and the Department. During this process, the Contractor and the District Team shall define the issues that contribute to the problem priority area, clearly define the characteristics of the target population, and negotiate milestones, short-term outcomes, target rates or other items in the plan of work.

Completed proposals and MCH Scoring Guide (see Appendix C) received by the MCH District Team on or before June 11, 2004, will be considered for the FFY 2005 contract. Proposals received after June 11, 2004 may be given consideration if time allows and only in the order they were received. Discussion meetings to complete the proposals are by appointment and scheduled through the MCH District Team. Contractors are encouraged to make the appointment for discussion meetings early.

The District MCH Team by July 29, 2004 and the Department – Central Office, by August 6, 2004, must receive finalized proposals. The timeline for contract preparation is specified in Section AA of this document. Both the MCH District Team and the Contractor must agree to the proposal in advance of the contract process. Once the District Team and the Contractor are in agreement on the proposal to be submitted to the Department Central office for final review, the plan will be sent to the MCH Program Manager. The negotiation process may begin any time after receipt of the Invitation For Proposals.

Section 2: Terms and Conditions ***(Continued)***

J. Clarification

The Department reserves the right to request clarification of information submitted and to request additional information regarding the proposal.

K. Authorized Signature

The signature of the offeror must be that of a Director or other duly authorized individual of the agency/jurisdiction submitting the proposal. One copy of the proposal must have a manual signature. The additional two sets of the proposal may be copies.

L. Award

Funding for FFY 2005 is non-competitive and awarded using a base amount of $15,000 plus a proportion of total funds based on each county's respective female-child poverty ratio[1].

The award amounts for each county/city (see Appendix E) are calculated based on FFY 2005 Federal funding, the 2000 census, and 1998-2002 birth certificate data. Award amounts for subsequent years will be affected by the Federal funds available to Missouri.

M. Joint Submission

Agencies may work collectively in multi-county groups to address needs across a larger population base. In such cases, funding will be based on the total available to the jurisdictions working in the collaborative relationship. Multi-county proposals must address the priority problem areas identified for each jurisdiction and must describe how the contract effort is to be distributed among the jurisdictions. One (1) agency must be designated as the Contractor. Letters of agreement are required if there is a multi-county plan of work or if the plan of work involves working with other health departments. Letters of agreement must be included with the contract proposal.

N. Contract

When the proposal is completed and submitted to the Department, the complete proposal shall be appended to the contract as Exhibit 1, and shall be incorporated as an integral part of the contract.

O. Contract Model

Beginning in FFY 2003, the MCH Outcome Funding Plan tied performance to contracting decisions through the use of performance incentives. The contractor will be accountable for achieving the negotiated outcomes. The Contractor and the Department shall follow the MCH Outcome Funding Plan for FFY 2005 and successive years of the contract. (see summary in Appendix F)

In the event that a contractor is not making progress on the plan of work defined in the contract, the contractor will be facilitated given technical assistance by the MCH District Team to help determine how to get back on track with the plan of work or whether re-negotiation of the proposal is needed.

[1] A female child poverty index factor is determined for each county in Missouri by the Center for Health Information Management and Epidemiology (CHIME). The female child poverty index is a composite of two (2) factors for each of the 115 jurisdictions: Maternal-infant indicator (births to adolescents, or infant and fetal deaths, or low birth weight) and Women (15-44) and children (under age 18) under 185% of poverty. The female child poverty index for the FFY 2005 MCH Contract is based upon the most current data available: 1998-2002 data for births, fetal and infant deaths and Census 2000 poverty data. The base-funding amount is multiplied by 115 and subtracted from the total funding amount for the contract. The difference is then multiplied by the female child poverty index factor for each county and added to the base-funding amount to arrive at the total award amount for each LPHA.

Section 2: Terms and Conditions *(Continued)*

The individual contract amounts will be divided into two fund categories: Assured Funds and Provisional Funds. In FFY 2005, 40% will be in the Assured Funds category and 60% will be in the Provisional Funds category. Payments to contractors will be paid out in equal monthly payments using funds from both categories. The first incentive applies to incentives for the contractor to retain Provisional Funds.

During the negotiation phase, the Contractor will negotiate conditions for each short-term outcome in the contract. The conditions may simply be viewed as the contractor's confidence in being able to achieve their short-term outcomes. The conditions are a reflection of the LPHA's expectation of their own success.

The conditions will be locally determined based on measurable short-term outcomes established during negotiation between the LPHA and the MCH District Teams. Each proposal is discussed and negotiated solely on its own merits.

During the negotiation, the question to be answered is "How high is the likelihood that the contractor will achieve the short-term outcome?" The relationship between the achievement of short-term outcomes and the expectation of success will depend on a variety of local factors.

A percent of confidence is negotiated and attached to each short-term outcome. The percent of confidence can be no lower than 5% for any short-term outcome. The dollar value attached to each short-term outcome is the percent of the Provisional Funds category only.

At year-end, if all short-term outcomes are met, the Contractor retains all Provisional Funds. If a short-term outcome is not met, then adjustments will be made based on the negotiated percentage. The Contractor has the choice of having the adjustment made from the Assured Funds category in the next year's contract award or to issue a check to the Department.

The Performance Measure Targets, the short-term outcomes and the conditions for Provisional Funds are all negotiated and agreed upon by the Contractor and the MCH District Team. The intent is that each contract be achievable so that each Contractor is successful.

Over the next two years (FFY 2006 – FFY 2007), the amounts in each fund category will change 10% each year. The amount in the Assured Funds category will be decreased 10% each year. The amount in the Provisional Funds category will be increased 10% each year.

The second focus of incentive is attached to making a change in the Performance Measure Targets. Because of the amount of time it takes to change health status indicators, the targets will be assessed following the initial three years of the new contract design (FFY 2002 – FFY 2004). An Incentive Award will be made based on a formula. Refer to Appendix G. A portion of the formula will be the percent of improvement in the identified performance measures. The Incentive Award will be allocated to the Contractor's Funds Assured category for the following contract year.

The money for Incentive Awards will come from two sources. The first is funds that were allocated to an LPHA/jurisdiction that chose not to participate in the FFY 2005 contracts. The second source is the contract funds accumulated through Provisional Funds returned in FFY 2005. In future years, the incentive pool will be based on those funds, if available, from the previous contract year.

The conditions for receiving an Incentive Award are: 1.) The negotiated Performance Measure Targets cannot have changed during the previous three years, and 2.) The Contractor has met or exceeded the Performance Measure Target.

Section 2: Terms and Conditions *(Continued)*

Whether there are funds in the incentive pool or how much money is in the incentive pool is an unknown. It is desired that every LPHA participate in the MCH contract and achieves all short-term outcomes. Assuming both of the above occur, there may not be an incentive pool.

The contractor is expected to submit all reports and invoices by the contract deadline, and attend two District meetings. One meeting is held in the fall to officially open the contract. The second required meeting is the spring pre-contract meeting. While all MCH meetings are developed to meet the education needs expressed by Contractors, any other district meetings provided by the MCH program are considered optional.

P. Period of Contract

The MCH contract will be a one-year contract, from October 1, 2004 to September 30, 2005. Contractors will have the option of two additional renewal years, by mutual agreement between the Department and the Contractor, assuming satisfactory Contractor performance. In order to take advantage of the renewal option, the Contractor will have to prepare at a minimum, a two-year plan of work. The Contractor may choose to prepare a three-year plan of work. The contracts will be prepared as one-year contracts.

Q. Amendments

During the contract year, no later than six months prior to the end of the contract, the contract may be amended. The Contractor may re-negotiate Performance Measure Targets, target population and contract short-term outcomes. The contractor may substitute short-term outcomes if the Department feels they are of equal value to the original outcomes. Acceptance of substitute outcomes is discretionary on the part of the Department. Anything re-negotiated will be handled with an amendment. It is not acceptable to increase the short-term outcome for one health indicator and to decrease the short-term outcome for another indicator, simply because one is going well and the other is doing poorly.

Requests for amendment are to be submitted to the MCH District Team. Both the MCH District Team and the Contractor must agree to the proposed amendment in advance of submitting the amendment to the Department. The Contractor and a MCH District Team member must sign and date the amendment prior to submitting the document to the Department.

The Department reserves the right to request clarification of the amendment submitted and to request additional information regarding the amendment.

R. Reporting Requirements

1.) Milestones: Progress toward the planned milestones will be monitored by quarterly reports submitted to the Department. The reports will be a brief description of performance in achieving the milestones that were set for the quarter. Reports are due on the last day of the months of January, April, July and October. (see report forms/format in Appendix H)

Reporting elements that are required for milestones in a brief two-page description, are as follows:

a.) Progress toward achieving the milestones. Provide the evaluation data to support the achievement of milestones. Milestones are not a listing of activities completed.

b.) If milestones were not achieved, indicate the reasons and future plans to achieve the milestones.

c.) Areas where milestones were exceeded.

Section 2: Terms and Conditions *(Continued)*

The report format will, in two pages or less, state the milestones that were to be achieved during the three-month reporting period, report the information or data, that explains the completion of specified milestones or report progress toward achieving the milestones. If no milestones were defined for the reporting period, explain the progress for achieving future milestones.

For milestones that were not achieved, explain why, what barriers were encountered, and what corrections are in place to achieve the milestones. Describe favorable developments, which enabled meeting the milestones sooner than anticipated, or producing more beneficial results than originally anticipated.

The Contractor shall inform the Department of any significant delays or adverse conditions, actual or anticipated, as soon as they become known if they will materially affect the milestones or cause the plan of work to fall behind schedule.

2.) Financial Report and Report of Compliance with Special Provisions: Compliance with special provisions of the contract and use of contract funds will be monitored by quarterly reports submitted to the Department. The reports, due on the last day of January, April, July and October, include the following reporting elements:

a.) Enter on Line 1, the amount of funds invoiced to the Department during the reporting period.

b.) Enter on Line 2, the amount of funds expended by the Contractor in meeting the contract outcomes.

c.) Subtract the amount expended from the amount invoiced.

d.) If the amount of funds expended by the Contractor in meeting the contract outcomes is greater than the amount invoiced, skip Line 4 and go to Line 5.

e.) If the amount invoiced is greater than the amount expended, the contractor will indicate whether:

- The remaining funds will be spent on meeting the outcomes in the MCH plan of work.
- The difference was spent on other MCH issues as specified in part 6.9 of the contract Scope of Work.
- The difference will be spent on other MCH issues as specified in part 6.9 of the contract Scope of Work.

f.) In fulfilling this contract the Contractor will assure with their name on Line 5, compliance with the following special provisions.

- Has developed and implemented a written plan for continuous quality improvement.
- Has not used MCH contract funds to replace or supplant state or federal funds for any service included in this contract.
- Has not used MCH contract funds for purpose of performing, assisting, or to encourage abortion.
- Has not charged individuals with income below 100% of the federal poverty guidelines for services provided using MCH contract funds.

g.) The name of the contractor's fiscal officer or director/administrator will be submitted on the Quarterly Financial Report, certifying the funds have been expended as specified by the terms and conditions of the contract. An ink-signed form is not required.

Section 2: Terms and Conditions *(Continued)*

3.) **Match Funding**: In order to receive federal Title V MCH Block Grant funds, the State of Missouri must match three non-federal dollars for every four federal dollars expended. It is important to meet this because State supported appropriations for maternal and child health related work is shrinking. The Department is asking for a commitment from each LPHA to make a good faith effort to help the State meet this obligation by reporting the local dollars spent on MCH that is not used ybby the LPHA for other matching purposed. The Department recognizes that the amount of match funds by every jurisdiction may vary somewhat. The Department is not requiring a fixed amount of match.

Quarterly reporting of local match dollars may be a cash match from any non-federal source, and must be clearly documented as efforts towards maternal and child health. Any funds offered as match may not also be used to match in another funding source. (see Match Funding Reporting form in Appendix H)

Matching local funds expenditures may include the following:

a.) Personnel salary costs.

b.) Fringe benefits paid to employees.

c.) Travel expenses, such as mileage, meals, lodging for work or to attend professional development workshops for maternal and child health.

d.) Purchase of equipment, excluding the purchase of major medical equipment, may include such items as audio-visual equipment, examination equipment, or other equipment purchased with local funds and used to support maternal and child health work.

e.) Purchase of supplies, including office supplies and any materials purchased specifically for maternal child health work.

4.) **Short-term Outcomes**: An annual performance report, due on October 30th following the end of the contract period, will report on the short-term outcomes as defined in the contract plan of work.

The information in the reports will get at issues such as: What results were produced, why, and what's next? Were there any external factors or unanticipated effects, adverse or even beneficial, that had an impact on achieving the outcomes? Were barriers encountered? What got in the way? What tripped you up?

The report elements required for short-term outcomes shall, in no more than two pages, state the outcomes that were to be achieved during the contract-reporting period, describe the progress of the plan of work for the contract period, and for each short-term outcome, describe the following:

a.) Your progress toward achieving the outcome, including the data to verify the outcome was met.

b.) If outcomes were not achieved, indicate the reasons and future plans to achieve the outcomes, and

c.) Areas where short-term outcomes were exceeded.

S. Submission of Report Forms

In an effort to conserve staff time, postage and other resource quarterly and annual report forms are to be submitted electronically. Contractors are to send reports by e-mail to the MCH Program Manager and to the MCH District Team members.

Section 2: Terms and Conditions *(Continued)*

T. Payments

The contract award amount will be disbursed in equal monthly payments, following the Department's receipt on an invoice from the Contractor. The Contractor shall use the Vendor Request For Payment (DH-38) standard invoice form/format for MCH billing (see example invoice in Appendix I.

Invoices submitted to the Department shall be uniquely identifiable invoices. Uniquely identifiable means the invoice can be distinguished by invoice number from a previously submitted invoice. The format for invoice numbers for the MCH contract is to be as follows: "MCH" to identify the program; two digits for the month, and two digits for the calendar year; (i.e.; the invoice number for the month of October 2004 would be entered as "MCH 10-04").

Monthly invoices are due on the last day of the month following each contract month. The final invoice is due to the Department on October 30th following the end of the contract period.

U. Distribution of Incentive Funds

An incentive is attached to making a change in the Performance Measure Targets. The Performance Measure Targets for future years are negotiated and agreed upon by the Contractor and the MCH District Team.

Because of the amount of time it takes to change health status indicators, the targets will be assessed following the initial three years of the new contract design (FFY 2002 – FFY 2004). An Incentive Award will be made based on a formula. A portion of the formula will be the amount of improvement in the identified performance measures. A description of the allocation formula may be found in Appendix G.

The Incentive Award will be allocated to the Contractor's Assured Funds category for the following contract year. The money for Incentive Awards comes from two sources. The first is funds that were allocated to a local public health jurisdiction that chose not to participate in the FFY 2003 and FFY 2004 contracts. The second source is the contract funds accumulated through Provisional Funds returned in FFY 2003 and FFY 2004. Beginning in FFY 2006 the incentive pool will be based on those funds, if available, from only the previous (FFY 2005) contract year.

The conditions for receiving an Incentive Award are: 1.) The negotiated Performance Measure Targets cannot have changed during the previous three years, and 2.) The Contractor has met or exceeded the FFY 2005 Performance Measure Target.

Whether there are funds in the incentive pool or how much money is in the incentive pool is an unknown. It is desired that every LPHA participate in the MCH contract and achieves all short-term outcomes. Assuming both of the above occur, there may not be an incentive pool.

V. Use of Funds

Contract funds must be used to address MCH issues. MCH contract funds must be expended during the current contract year. The Contractor may subcontract funds for contract activities. Funds may not be used for cash payments to intended recipients of health services or for purchase of land, buildings or major medical equipment.

W. LPHAs as Medicaid Providers

No contract provisions preclude the Contractor from being a Medicaid provider. Contractors shall not use contract fund for services reimbursed under Medicaid.

Section 2: Terms and Conditions *(Continued)*

X. On-Site Visits

During the contract year the MCH district staff will assess the Contractor's compliance with the terms of the contract, to verify the Contractor is making progress to achieve the contract outcomes and to assess local capacity to support the MCH Ten Essential Services.

District staff will assess to see that public health services encompassed by the contract are being addressed and that the agreed upon components of the multi-tiered service coordination system exist or are being established.

The focus of this contract is on consultation and technical assistance to assist the Contractor in acquiring the resources and expertise necessary to address targeted performance measures.

Y. Contract Documentation Requirements

All contractors shall have documentation necessary to evaluate compliance with the terms of the contract. The documentation will provide the necessary evidence to determine contract compliance.

1.) Quarterly report forms, to document performance toward meeting the contract outcomes, for the reporting period being reviewed.

2.) Documentation to verify achievement of the short-term outcome specified in the MCH plan of work.

3.) Financial verification will focus on assurance that funds were expended for MCH issues and verification of local match expenditures.

Z. Technical Assistance

The Department wants to maximize what can be delivered for the MCH dollars available by providing technical assistance. Education will be provided based on an assessment of the professional development needs of Contractors. The Department will consider other requests for appropriate technical assistance.

AA. Calendar of Events

Event	Deadlines For FFY 2005 MCH Contract
Invitation for Proposals (IFP) will be posted on the DHSS website.	03-31-04
Letter of Intent received by the Department – Central Office, MCH Program Manager.	04-30-04
Proposal and completed MCH Scoring Guide must be submitted to the MCH District Team for review on or before. Appointments for final discussion meetings with Contractors may begin any time after receipt of IFP.	06-11-04
Negotiation of proposed plan of work with MCH District Team must be completed.	07-29-04
The Department - Central Office, must receive final plan of work.	08-06-04
Final contract awards sent to Contractor for signature.	08-16-04
Signed contract received by the Health Communities and Schools Unit.	09-15-04
Contract begins.	10-01-04

The letter of Intent to Contract is to be received (by personal delivery, mail, or fax) by the MCH Program Manager, in the Healthy Communities and Schools Unit, by **5 p.m.** on the deadline date indicated.

Section 2: Terms and Conditions ***(Continued)***

The initial plan of work must be submitted to the MCH District Team. Completed proposals received by the MCH District Team on, or before, June 11, 2004, will be considered for the FFY 2005 contract.

Discussion meetings to complete the proposals are by appointment and scheduled through the MCH District Team.

The MCH Program Manager, in the Missouri Department of Health and Senior Services, Healthy Communities and Schools Unit, shall receive the final copies of the plan of work, by **5 p.m**. on the deadline date indicated**.** The plan of work will be reviewed, and may be accepted or returned for clarification or changes. Contractors will be notified as soon as possible when their plan of work requires clarification or changes.

Final contract award packets will be mailed to the Contractor for signature by the date indicated in the table above. The signed contract (DH-70), along with the approved plan of work and scope of work, must be returned to the Department by the date indicated.

The contract period will be the federal fiscal year, October 1, 2004 through September 30, 2005.

Appendix A

Guidelines and Checklist for Preparing MCH Proposals

NOTE: Proposals are to be prepared using a font size of twelve (12).

Section One: Cover Page - Agency Information

Instructions: Complete the cover page of the proposal. Agency information must be on the first page of your proposal. The original copy of the proposal must have an original signature and contain the following information:

1. Name of the agency or agencies involved.
2. Contact person and the telephone number.
3. Name of area(s) to be served.
4. Authorized signature and date.

Section Two: Plan of Work

Capacity Building Outcome for System Development

NOTE: This element is new and is designed to help the LPHA identify systems and capacity gaps and to design processes for systems improvement. This component, while not part of the negotiated percentage conditions elsewhere required, will help in the development of your proposed system.

Instructions: Based on the MCH Ten Essential Services capacity assessment process, complete a separate short-term outcome for an MCH Essential Service. For best results toward systems development, be sure to address each category listed below.

A. MCH Essential Service to be addressed and Statement of the Problem

MCH Essential Service:
Instructions: What is the MCH Essential Service you are working on?

Statement of the Problem:
Instructions: What is the story behind the data? What are the root causes that contribute to this problem? What are all of the things that contribute to this being a problem in your community?

B. Description of Target Population

Instructions: Given what contributes to this being a problem in your community, and what is being done to address the problem, what group has been chosen to work with as the target population? Provide the following information about the target population:

- *What is the target population?*
- *Size of the target population?*
- *What are the unique characteristics of the target population, which made the community choose them for the intervention?*

C. Short-term Outcome (No Negotiated Condition for capacity building short-term outcome required.)

Instruction: Given the target population chosen, and the improvements planned for the coming year, what outcome do you expect to achieve? What is the behavior change you want to see as a result of the intervention? By what date do you expect to see the completed outcome results? What will be measured to verify the results achieved? How will the outcome be documented in order to verify the results?

D. Milestones

Instruction: While the intervention is being done, milestones help tell if the intervention is working and on-track. As the intervention is occurring, are the expected incremental changes happening? Milestones are not a listing of activities to be done.

E. Key Individuals

Instructions: Who is the one person who will coordinate the work for this short-term outcome? What is their name? Why is that person the best person?

F. Community Partners

Instructions: This section will show how the community plan will work. This is where you describe what will be done by other community partners to help increase the probability of success of the intervention and to help build community capacity. This is where the community plan of action should show up. Show the community partner's investment in the plan.

Health Performance Measure Outcomes

Instructions: Complete a separate plan of work for a minimum of two and a maximum of four Problem Priority Areas targeted for intervention in the FFY 2002 MCH contract. (see page 8 of the MCH Program Guidance, for selection criteria.) Be sure to address each category listed below.

In this contract 30% of the Contractor's efforts must be directed toward children with special health care needs. Efforts directed toward children with special health care needs must be identified in the plan of work with an asterisk.

A. Priority Problem Area and Statement of the Problem

Priority Problem Area:
Instructions: What is the priority problem area you are working on?

Statement of the Problem:
Instructions: What is the story behind the data? What are the root causes that contribute to this problem? What are all of the things that contribute to this being a problem in your community? This could be the information from a causal diagram.

B. Existing MCH Service Coordination System

Instructions: Describe the way the existing MCH service coordination system works. Describe the role of community partners and the contractor's role in the existing system. For each of the six elements, describe what is happening currently at the individual level, at the community level and at the system level.

Definitions for each level:

Individual: Interventions that work to change the knowledge, attitudes, beliefs, practices, skills and behaviors of individuals. The interventions are focused on individuals alone, or as part of a family or group.

Community: Interventions that are focused to changing community norms, community attitudes, community awareness, community practices, and community behaviors. Interventions may be directed at the entire population in a community or sometimes toward target groups within the population.

System: Interventions work to change organizations, policies, laws, and power structures. There is less of a focus on the individuals and community, and more focus on the systems that impact health.

Example: As it relates to the education component, for the prevention of youth smoking.

Individual: The Jefferson Middle School, health department, and law enforcement staff collaborates to implement the youth smoking prevention intervention that increases knowledge of the risks of smoking, change attitudes toward tobacco use, and improve resistance skill among students 12-14 years of age.

Community: The health department staff coordinates a youth led public campaign to change community norms about tobacco use among youth.

System: The _____ County Healthy Community Coalition will work with the city council in Happy Town and Other Town to enforce laws restricting the sale of tobacco to youth.

1. Identification: What is being done now to diagnose and investigate health problems and health hazards for women, children and youth? What is being done now to research or find new solutions to MCH problems?
   Individual:
   Community:
   System:
2. Assessment: How does your community currently assess and monitor MCH status to identify and address problems?
   Individual:
   Community:
   System:
3. Referral: How do community partnerships currently work between policymakers, health care providers, families, the general public, and others to identify and solve MCH problems? What is currently occurring to link women, children and youth to health and other community and family services, and to assure access to comprehensive, quality systems of care?
   Individual:
   Community:
   System:
4. Assurance: What is currently happening to assure the capacity and competency of the public health and personal health workforce to effectively address MCH needs? How does your community currently promote and enforce legal requirements of the public health and personal health and safety of MCH population, and ensure accountability for their well being?
   Individual:
   Community:
   System:
5. Education: How does your community currently inform and educate the public and families, the general public, and others to identify and solve MCH problems?
   Individual:
   Community:
   System:
6. Evaluation: How does your community currently evaluate the effectiveness, accessibility, and quality of personal health and population-based MCH services? In what ways does your community currently provide leadership for setting priorities, planning, and policy development to support community efforts to assure the health of MCH population?
   Individual:
   Community:
   System:

C. Description of Target Population

Instructions: Given what contributes to this being a problem in your community, and what is currently being done to address the problem, what group has been identified to work with as the target population? Provide the following information about the target population:

- *What is the target population?*
- *Size of the target population?*
- *What are the unique characteristics of the target population which made the community choose them for the intervention?*
- *What is the baseline data of the target population that relates to the intervention to be used?*
- *What were the results of the intervention last year and other previous years? This is very important to have before writing the short-term outcome.*

D. Proposed MCH Service Coordination System

Instructions: Describe what your community proposes for the next year to make the MCH Service Coordination System better. Given the way the community system currently works, the target population identified, and the current system capacity, what will be done in the next contract year to help make the system stronger?

1. Identification: What else will be done or what changes need to be made to better diagnose and investigate health problems and health hazards for women, children and youth? What else will be done to research or find new solutions to MCH problems?
   Individual:
   Community:
   System:
2. Assessment: How will your local processes improve to better assess and monitor MCH status to identify and address problems?
   Individual:
   Community:
   System:
3. Referral: How will community collaboration be strengthened (between policy makers, health care providers, families, the general public, and others) to identify and solve MCH problems? What will change to link women, children and youth to health and other community and family services, and to assure access to comprehensive, quality systems of care?
   Individual:
   Community:
   System:
4. Assurance: What else will be done to assure the capacity and competency of the public health and personal health workforce to effectively address MCH needs? What needs to change at the community level to better promote and enforce legal requirements of the public health and personal health and safety of MCH population, and ensure accountability for their well being?
   Individual:
   Community:
   System:
5. Education: How will the community change to better inform and educate the public and families, the general public, and others to identify and solve MCH problems?
   Individual:
   Community:
   System:

6. Evaluation: What changes will your community make to better evaluate the effectiveness, accessibility, and quality of personal health and population-based MCH services? In what ways will your community change to provide leadership for setting priorities, planning, and policy development to support community efforts to assure the health of MCH population?

Individual:
Community:
System:

E. Short-term Outcome and Negotiated Condition for Short-term Outcome =_____ %

Instruction: The short-term outcome is the strongest measure to see if the intervention worked. Given the target population chosen, the improvements planned for the coming year, and the intervention to be used next year, what outcome do you expect to see? What is the behavior change you want to see as a result of the intervention? Just give one behavior change. By what date do you expect to see the behavior change? How will the results be documented to verify the results achieved? *Example: By (Date: Month, day and year), X percent of (target population) will (give the changed behavior you hope to see), as verified by (tell how the data will be permanently documented).*

F. Milestones

Instruction: While the intervention is being done, milestones help tell if the intervention is working. As the intervention is occurring, are the expected incremental changes happening? Are people learning the things the intervention said they should learn? Are people making changes in their attitude about risky behaviors or healthy behaviors? Are they learning skills to help them break the unhealthy habits or use healthy habits? Milestones are not a listing of activities to be done.

G. Key Individuals

Instructions: Who is the one person who will coordinate the work for this performance measure? What is their name? Why is that person the best person?

H. Community Partners

Instructions: This section will show how the community plan will work. This is where you describe what will be done by other community partners to help increase the probability of success of the intervention and to help build community capacity. This is where the community plan of action should show up. Show the community partners investment in the plan.

Section Three: Negotiated Priority Problem Areas

Instructions: If you believe a Priority Problem Area highlighted by the Department is adequately addressed in your community, you may choose an alternate Priority Problem Area to address. However, for the Priority Problem Area highlighted by the Department that has data which is worse than the State rate, you must describe the following: How the MCH multi-tiered Service Coordination System needs are being met, the agency or agencies that are addressing the Priority Problem Area, and the Contractor's involvement in the community's addressing of the Priority Problem. Provide supportive data and documentation to explain the reason for selecting an alternate or additional problem area. This applies to MCH problem areas highlighted by the Department that have the notation of "X" and "NA" under the column heading "County State Variance."

For highlighted MCH problem areas where the county/city baseline data are not statistically significant, the Contractor may request to target another problem area without having to provide supporting information. This applies only to Priority Problem Areas highlighted by the Department that have the notation of "N/S" under the column heading "County State Variance."

A. For the Priority Problem Areas proposed as adequately addressed within the community complete the following information:

1. Problem Priority Area.
2. Describe how the MCH multi-tiered Service Coordination System and system component needs are being met.
3. Describe the agency or agencies in the community that are involved in addressing the Priority Problem Area.
4. Describe the Contractor's involvement in the community's addressing of the Priority Problem.

B. For each Alternate and/or Additional Problem Area to be considered for negotiation by the Contractor, complete the following:

1. Provide supportive data and documentation to explain the reason for selecting alternate or additional problem area(s).
2. Proceed by providing information as describe in Section Two steps A – H.

Instructions and Checklist for Submitting Proposals

Section One: For submission to the MCH District Team for final review

A. Assemble an electronic copy of the full proposal.

B. Send by e-mail, an electronic copy of completed proposal to both the MCH District Nurse Consultant and the Community Support Consultant.

C. Send completed MCH Scoring Guide to both the MCH District Nurse Consultant and the CHART Community Support Consultant.

D. Submission Deadline: the MCH District Team must receive proposals by June 11, 2003.

NOTE: Completed proposals received by the MCH District Team on, or before, June 11, 2004, will be considered for the FFY 2005 contract.

Section Two: For submission of Final Proposal Packet to DHSS – Central Office

A. Assemble original copy of proposal. Proposal items are to be in the following order:

1. Scope of Work ***NOTE:*** *Use the Scope of Work as printed in the FFY 2005 MCH Program Guidance.*
2. Cover Page – *Includes agency information with authorized original ink signature and date.*
3. Proposal for each problem priority area and capacity building outcome.
4. Negotiated Priority Problem Areas (if applicable).
5. Performance References Spreadsheet – *NOTE: Spreadsheet must be signed and dated by Contractor and an MCH District Team member*.
6. Letters of Agreement, if submitting a multi-county proposal.

B. Prepare two copies of completed proposal.

C. Send the <u>original</u> and <u>two copies</u> of completed proposal. Faxed and electronic copies will not be accepted.

D. Send complete proposal packet to your MCH District Nurse Consultant. Prior to mailing to Central Office by July 29, 2004, the MCH District Team will review the packet.

E. Submission Deadline to Department of Health and Senior Services – Central Office:
Must be received by 5 p.m., on August 6, 2004.

Appendix B

Elements of FFY 2005 MCH Contract

Purpose: To establish an integrated multi-tiered service coordination system (individual, community and system) capable of adapting to address targeted maternal-child health issues.

MCH Service Coordination System:

Components of System	Related MCH Essential Service
Identification	• Diagnose and investigate health problems and health hazards affecting women, children and youth. (2) • Support research and demonstrations to gain new insights and innovative solutions to MCH problems. (10)
Assessment	• Assess and monitor maternal and child health status to identify and address problems. (1)
Referral	• Mobilize community partnerships between policymakers, health care providers, families, the general public, and others to identify and solve MCH problems. (4) • Link women, children, and youth to health and other community and family services, and assure access to comprehensive, quality systems of care. (7)
Assurance	• Assure the capacity and competency of the public health and personal health workforce to effectively address MCH needs. (8) • Promote and enforce legal requirements of the public health and personal health and safety of MCH population, and ensure accountability for their well being. (6)
Education	• Inform and educate the public and families, the general public, and others to identify and solve MCH problems. (3)
Evaluation	• Evaluate the effectiveness, accessibility, and quality of personal health and population-based MCH services. (9) • Provide leadership for setting priorities, planning, and policy development to support community efforts to assure the health of MCH population. (5)

Appendix C

MCH Scoring Guide

Score Sheet for Reviewing FY 2005 MCH Proposals

Date Rcvd: Reviewer: Contractor/Agency:

	Section One: Cover Page – Agency Information	Points Possible	1	2	3	4
1	Name of the agency or agencies involved	0-0.25				
2	Contact person and the telephone number	0-0.25				
3	Name of area(s) to be served.	0-0.25				
4	Authorized signature and date.	0-0.25				
	Section Two: Plan of Work					
	A. Priority Problem Area and Statement of the Problem					
1	Expanded description: Details of what contributes to this being a problem in the county, or area.	0-9				
2	Not limited to DHSS data: Goes beyond stating county & state rates, and is relevant and specific to the problem.	0-3				
	B. Existing MCH system					
1	Includes 6 separate components: Describes how the system addresses each component and shows growth from previous year.	0-4				
2	Not limited to LPHA activities: Describes a community collaborative approach.	0-3				
3	Includes community partners: Describes how other partners are addressing the problem.	0-4				
4	Indication of multi-level system: Shows what is happening in the community at the individual, community and system levels.	0-4				
	C. Description of Target Population (TP)					
1	Includes characteristics of TP: Describes TP and how it is appropriate to the behaviors to be changed.	0-3				
2	Includes numeric information for the TP: Size of TP and baseline data for the behaviors targeted by the intervention and the source of the information.	0-4				
3	Focused on same TP as previous year: Consistent focus on same TP over time, or change has been justified.	0-3				
	D. Proposed MCH Service Coordination System					
1	Included 6 separate components: Describes growth planned for the coming year.	0-4				
2	Not limited to LPHA activities: Describes a community collaborative approach.	0-1				
3	Includes community partners: Should see an expansion of existing partner effort and/or new partners added.	0-4				
4	Indication of multi-level system: Shows what is happening in the community at the individual, community and system levels.	0-6				
	E. Short-term Outcome					
1	States a behavior change: The intervention is evaluated to measure change in behavior in the TP, which will also lead to improvement in the performance measure.	0-5				
2	Date to be achieved: Date by which outcome will be met.	0-1				
3	Measurement criteria: Includes % (or number) of people, & the percent, or degree, of change expected.	0-4				
4	Verification method: Data source to document results.	0-1				
5	Directly linked to target population: The behavior change is for the TP described.	0-5				
	Negotiated Condition for Short-term Outcome:					
1	Included for performance measure. Value for each outcome is equal to, or greater than 5%	0-1				
2	Totals 100%: Totals of negotiated conditions equals 100%	0-1				
	F. Milestones					
1	States a change in KAS: Intervention is evaluated to measure change in knowledge, attitude and skills. Can determine from the milestones, how the intervention is to be evaluated.	0-4				
2	Date to be achieved: The intervention has an incremental evaluation timeline.	0-1				
3	Measurement criteria: Includes percent, or number, of people, and the percent, or degree, of change expected.	0-1				
4	Verification method: Data source to document evaluation results.	0-1				
5	More than one milestone: There are measurements to show incremental evaluation.	0-3				
6	Directly linked to short-term outcome: Milestones show linkage to meet the short-term outcome.	0-2				
	G. Key Individuals					
1	Name of key person given: States who is the single individual that has lead oversight of the intervention, or project.	0-2				
2	Describes why they are the right people.	0-2				
	H. Community Partners					
1	Name of partners: Described by agency and/or individual name.	0-3				
2	Partner's unique contribution specified: The detailed implementation plan for the *intervention* and *system services* is defined. Clearly describes partner's contribution.	0-6				
3	Reference to community coalition: Shows the role of an on-going community planning group.	0-4				
		Total for each performance measure: 100				

- CSHCN: Asterisks are present to indicate effort for CSHCN. Yes No
- Performance References Spreadsheet: Edits to targets are clearly legible and sheet is signed by Contractor and district team member. Yes No
- Final Packet: The four copies are identical to the original copy. Yes No
- Letter(s) of Agreement are included for multi-county proposals. Yes No NA

Mean Score: ____

Appendix D

Core Elements of the MCH Contract

Service Coordination	Individual: The coordination of needed services when working with an individual or family. Interventions that work to change the knowledge, attitudes, beliefs, practices, skills and behaviors of individuals. * Community: The coordination functions performed to assure that preventive interventions and services are available for the entire MCH population of the jurisdiction. Interventions are focused to changing community norms, community attitudes, community awareness, community practices, and community behaviors. Interventions may be directed at the entire population in a community or sometimes toward target groups within the population.* System: Activities directed at improving and maintaining the health status of all women and children by providing support for infrastructure development and maintenance of comprehensive health systems. Interventions work to change organizations, policies, laws, and power structures. There is less of a focus on the individuals and community, and more focus on the systems that impact health.* *This definition and service coordination system encompasses children with special health care needs.
Plan of Work	Contractor will develop a formal plan to address MCH population needs and the system components of service coordination. Using defined selection criteria, the plan of work must address 2, 3, or 4 problem priority areas identified on the MCH Performance Reference. DHSS will provide Contractors with MCH Performance References showing what particular MCH problem areas are targeted for intervention for each jurisdiction and will include target projections for future years. Other community funding sources may address problem areas. The Contractor with introduction of supportive data/documentation may negotiate additional MCH problem areas. Target projections are negotiable during the initial writing of the plan of work. Elements of plan: What the Contractor will do to address problem area(s) Evidence-based interventions Milestones and short-term outcomes for plan of work A timeline for achieving each outcome At a minimum, 30% of efforts must be directed toward children with special health care needs. Deliverables: Negotiated short-term outcomes
Negotiation Phase	Plan will be submitted to District staff for review and negotiation. Negotiated plan submitted to DHSS.
Reporting	Progress toward contract outcomes monitored by quarterly and annual reports submitted to DHSS.
Payments	Award amount disbursed in 12 equal payments.
Contract	Length of contract: One year with option of two additional renewal years. First year: The Contractor will be assured to receive the full contract amount in FFY02, providing good faith efforts are documented. Subsequent years: Beginning in FFY 2003, the MCH Outcome-funding Plan is implemented, and Contractor is accountable for negotiated outcomes. Contract outcomes will be tracked by the program manager. During the contract year the Contractor can substitute outcomes, if the DHSS determines they are of equal value to the original outcomes. Acceptance of substitute outcomes is discretionary on the part of the DHSS. Funding: Non-competitive, based on current allocation formula and MCH Outcome Funding Plan.
On-site visits	MCH District staff will monitor to see that public health services encompassed by the contract are being addressed and agreed upon components of multi-tiered service coordination system exist or are being established.
Technical Assistance	District meetings to discuss the contract design. Education will be provided based on assessment of the professional development needs of Contractors. Other appropriate technical assistance requests will be considered by the DHSS.

Appendix E

FFY 2005 CONTRACT AMOUNTS

COUNTY / CITY	Contract Amount
Adair	$ 22,375
Andrew	$ 18,604
Atchison	$ 16,553
Audrain	$ 23,278
Barry	$ 28,522
Barton	$ 19,131
Bates	$ 20,680
Benton	$ 19,772
Bollinger	$ 19,299
Boone	$ 56,898
Buchanan	$ 42,743
Butler	$ 31,054
Caldwell	$ 17,743
Callaway	$ 26,099
Camden	$ 24,410
Cape Girardeau	$ 33,788
Carroll	$ 17,861
Carter	$ 17,672
Cass	$ 33,191
Cedar	$ 19,357
Chariton	$ 17,011
Christian	$ 29,456
Clark	$ 17,085
Clay	$ 34,570
Clinton	$ 19,927
Cole	$ 30,869
Cooper	$ 19,182
Crawford	$ 23,643
Dade	$ 17,465
Dallas	$ 21,011
Daviess	$ 17,698
De Kalb	$ 17,872
Dent	$ 20,354
Douglas	$ 19,393
Dunklin	$ 30,710
Franklin	$ 38,976
Gasconade	$ 18,787
Gentry	$ 16,812
Greene	$ 32,950
Grundy	$ 18,597

COUNTY / CITY	Contract Amount
Harrison	$ 17,879
Henry	$ 21,453
Hickory	$ 17,541
Holt	$ 16,536
Howard	$ 17,972
Howell	$ 29,557
Independence City	$ 46,982
Iron	$ 18,997
Jackson	$ 60,883
Jasper	$ 38,515
Jefferson	$ 63,598
Johnson	$ 30,097
Joplin City	$ 32,247
Kansas City	$ 193,511
Knox	$ 16,355
Laclede	$ 27,171
Lafayette	$ 23,681
Lawrence	$ 28,114
Lewis	$ 18,139
Lincoln	$ 25,928
Linn	$ 19,523
Livingston	$ 19,598
Macon	$ 19,778
Madison	$ 19,413
Maries	$ 17,564
Marion	$ 24,268
McDonald	$ 25,236
Mercer	$ 16,183
Miller	$ 22,999
Mississippi	$ 22,597
Moniteau	$ 19,015
Monroe	$ 17,457
Montgomery	$ 18,587
Morgan	$ 21,445
New Madrid	$ 23,790
Newton	$ 30,141
Nodaway	$ 20,048
Oregon	$ 18,913
Osage	$ 17,599
Ozark	$ 18,323

COUNTY / CITY	Contract Amount
Pemiscot	$ 28,600
Perry	$ 20,342
Pettis	$ 29,263
Phelps	$ 28,296
Pike	$ 20,519
Platte	$ 22,006
Polk	$ 24,311
Pulaski	$ 30,005
Putnam	$ 16,890
Ralls	$ 17,235
Randolph	$ 23,521
Ray	$ 20,930
Reynolds	$ 17,635
Ripley	$ 21,145
Saline	$ 22,657
Schuyler	$ 16,346
Scotland	$ 16,478
Scott	$ 32,014
Shannon	$ 18,672
Shelby	$ 17,301
Springfield	$ 67,484
St. Charles	$ 67,154
St. Clair	$ 17,990
St. Francois	$ 34,123
St. Louis City	$ 207,876
St. Louis County	$ 246,190
Ste. Genevieve	$ 18,903
Stoddard	$ 25,435
Stone	$ 23,387
Sullivan	$ 17,874
Taney	$ 27,914
Texas	$ 24,280
Vernon	$ 21,908
Warren	$ 21,592
Washington	$ 25,685
Wayne	$ 20,114
Webster	$ 26,403
Worth	$ 15,595
Wright	$ 22,777

Appendix F

Division of Community Health – Section for Community Health Systems and Support
MCH Outcome Funding Plan

Year	Fund Category	Percent	Amount	Note:
FY01	% of Assured Funds	= 100%	$ 20,000	Current year. Cost reimbursement.
	% of Provisional Funds	= 0%		
FY02	% of Assured Funds	= 100%	$ 20,000	Negotiated conditions for Provisional Funds:
	% of Provisional Funds	= 0%	$ 0	- Though no funds will be assessed, LPHAs will negotiate an incentive condition for short-term outcomes.
	Negotiated conditions for Provisional Funds:			
	Example: Short-term Outcome #1	= 5%	$ 0	
	Short-term Outcome #2	= 15%	$ 0	
	Short-term Outcome #3	= 20%	$ 0	
	Short-term Outcome #4	= 60%	$ 0	
FY03	% of Assured Funds	= 60%	$ 12,000	Incentives for retaining Provisional Funds:
	% of Provisional Funds	= 40%	$ 8,000	- Based on negotiated conditions for short-term outcomes.
				- Payments are made based on Assured Funds and Provisional Funds.
	Negotiated conditions for Provisional Funds:			- If short-term outcomes are not met, then adjustments will be made from the Assured Funds amount in the next year's contract award or the Contractor will issue a check to the Department.
	Example: Short-term Outcome #1	= 20%	$ 1,600	
	Short-term Outcome #2	= 5%	$ 400	
	Short-term Outcome #3	= 35%	$ 2,800	
	Short-term Outcome #4	= 40%	$ 3,200	
FY04	% of Assured Funds	= 50%	$ 10,000	- Incentives continue as above.
	% of Provisional Funds	= 50%	$ 10,000	
	Negotiated conditions for Provisional Funds:		$ 1,000	
	Example: Short-term Outcome #1	= 10%	$ 1,500	
	Short-term Outcome #2	= 15%	$ 3,000	
	Short-term Outcome #3	= 30%	$ 4,500	
	Short-term Outcome #4	= 45%		
FY05	% of Assured Funds	= 40%	$ 8,000	Incentive Awards for Performance Measure Targets. *
	Incentive Award added	= -	$ 4,000	Example: Note that incentive is added to the Assured Fund category.
	% of Provisional Funds	= 60%	$ 12,000	- Incentives to retain Provisional Funds continue as above.
	Conditions for short-term outcomes negotiated annually.			
FY06	% of Assured Funds	= 30%	$ 6,000	- Continued monitoring of performance measures.
	% of Provisional Funds	= 70%	$ 14,000	- Incentives continue as above.
	Conditions for short-term outcomes negotiated annually.			
FY07	% of Assured Funds	= 20%	$ 4,000	- Continued monitoring of performance measures.
	% of Provisional Funds	= 80%	$ 16,000	- Incentive continues as above.
	Conditions for short-term outcomes negotiated annually.			

*** Determination of Incentive Award for Performance Measure Targets:**

1. Assess performance measure targets following the initial three years of new contract design.
2. Incentive Award based on percent of improvement for the county/city negotiated target set for identified performance measures.
3. Negotiated performance targets cannot have changed during the previous three years.
4. If targets have been re-negotiated, the Contractor is eligible for an Incentive Award three years later.
5. Performance measures have equal value.
6. The initial incentive pool is made up of:
   a. Funds allocated to LPHAs/jurisdictions that did not participate in the FY03 and FY04 contracts and,
   b. Contract funds accumulated through Provisional Funds in FY03 and FFY04.
7. A formula will determine the Incentive Award amount as described in Appendix G.
8. Incentive Awards cannot exceed the total amount in the Incentive Fund.
9. Incentive Awards will be allocated to Assured Funds for the following contract year.
10. In subsequent years after FY 04, the incentive pool will be based on funds allocated to LPHAs/jurisdictions that did not participate in the previous year's contract and funds accumulated through Provisional Funds in the previous contract year only.

Appendix G

Formula for Distributing Incentive Awards

Step One:	Obtain the total dollar amount available for disbursement.	Example: $50,000.00
Step Two:	Determine the base dollar amount to be awarded to each contractor that has met or exceeded a target. (Example: For reaching or exceeding a target, the contractor will receive $1,000. Multiply that amount by the total number of contractors who met or exceeded a target. If 15 contractors each met or exceeded only one target, then $15,000 would be deducted and the remaining funds are dispersed in Step Three. SUBTOTAL	-$15,000.00 $35,000.00
Step Three:	Count the number of points that each contractor went OVER the expected targets. Example: ("T" equals Performance Measure Target) Contractor #1: T 1 = 0.0, T 2 = 0.1, T 3 = 0.0 (0.0 + 0.1 + 0.0 = 0.1) Contractor #2: T 1 = 2.0, T 2 = 0.5, T 3 = 1.2 (2.0 + 0.5 + 1.2 = 3.7) Contractor #3: T 1 = 1.0, T 2 = 0.0, T 3 = 0.5 (1.0 + 0.0 + 0.5 = 1.5) Contractor #4: T 1 = 0.7, T 2 = 1.2, T 3 = 0.0 (0.7 + 1.2 = 0.0 = 1.9) TOTAL POINTS OVER TARGET	7.2
Step Four:	Apply the following to determine how to calculate the amount of money each full percentage point is worth: Total dollar amount Less Incentive for meeting or exceeding the target Equals remaining available dollars for disbursement Remaining available dollars for disbursement Divided by total incentive points earned Equals value of each incentive point Individual allotments for percentage points gained over each target: Contractor #1: 0.1 x $4,861.11 Contractor #2: 3.7 x $4,861.11 Contractor #3: 1.5 x $4,861.11 Contractor #4: 1.9 x $4,861.11 Amount distributed over and above initial distribution of $15,000.00	 $50,000.00 -$15.000.00 $35,000.00 $35,000.00 7.20 $4,861.11 $486.11 $17,986.11 $7,291.67 $9,236.11 $34,999.99

Appendix H

Reporting Forms/Format

FFY 2005 MCH Quarterly Report

Contractor: _____ Reporting Period: _____

Section One: Progress on Milestones

Instructions: Describe the progress in your work plan for the reporting period using the following format. For each milestone, describe: 1.) Your progress toward achieving the milestones, 2.) If milestones were not achieved, indicate the reasons and future plans to achieve the outcomes, and 3.) Areas where milestones were exceeded. Submit report by e-mail to both of the MCH District Team members and to *Department of Health and Senior Services, Healthy Communities and Schools Unit, MCH Program Manager.*

1.) Progress toward achieving the milestones. *(State the milestones that were to be achieved during the three-month reporting period, report the information/data that explains the completion of specified milestones or report progress toward achieving current or future milestones.) Provide the evaluation data to support the achievement of milestones. Milestones progress are not a listing of activities completed.*

2.) If milestones were not achieved, indicate the reasons and future plans to achieve the milestones. *(For milestones that were not achieved, explain why and what corrections are in place to achieve the milestones.)*

3.) Areas where milestones were exceeded. *(Describe favorable developments, which enabled meeting the milestones sooner than anticipated, or producing more beneficial results than originally anticipated.)*

Appendix H Reporting Forms/Format *(Continued)*

FFY 2005 MCH Quarterly Report

Contractor: _____ Reporting Period: _____

Section Two: Quarterly Financial Report and Report of Compliance with Special Provisions

Instructions: Enter the MCH financial information for the reporting period. Enter summary totals only. Submission of detailed expenditure information is not required. Attach Section Two report to the quarterly report on milestones, and submit report by e-mail to both of the MCH District Team members and to *Department of Health and Senior Services, Healthy Communities and Schools Unit, MCH Program Manager.*

Line 1 $_____ Enter the amount invoiced to DHSS during reporting period.

Line 2 $_____ Enter the amount expended by contractor in meeting the contract outcomes.

Line 3 $_____ Enter the difference between line 1 and line 2.

If difference is a positive amount, complete lines 4 and 5.

If difference is a negative amount, skip line 4 and go to line 5.

Line 4 *If line 3 is a positive amount, check all that apply below.*

NOTE*: MCH contract funds must be expended by September 30, 2005.*

☐ Funds will be spent on meeting outcomes in the MCH plan of work.

☐ Funds have been spent on other MCH issues as specified in part 6.9 of the contract Scope of Work.

☐ Funds will be spent on other MCH issues as specified in part 6.9 of the contract Scope of Work.

Line 5 In fulfilling this contract, our agency attests to compliance with the following special provisions: *Check all that apply below*

☐ Has developed and implemented a written plan for continuous quality improvement.

☐ Has not used MCH contract funds to replace or supplant state or federal funds for any service included in this contract.

☐ Has not used MCH contract funds for purpose of performing, assisting, or encouraging abortion.

☐ Has not charged Individuals with income below 100% of the federal poverty guidelines for services provided using MCH contract funds.

I certify to the best of my knowledge and belief that this report is correct and complete and that funds have been expended as specified by the terms and conditions of the contract.

_____ _____

Name of Authorized Official: Financial Office or Director *Date*

_____

Phone Number

Appendix H Reporting Forms/Format *(Continued)*

FFY 2005 MCH Quarterly Report

Contractor: _____ Reporting Period: _____

Section Three: Match Funding for Maternal and Child Health work. *

Expenditure Classification	Local Match Amount (non-federal)
Salaries (Including fringe benefits)	
Travel (Mileage, meals, lodging for work or to attend professional development workshops for maternal and child health.)	
Equipment (Excluding major medical equipment.)	
Supplies (Office supplies or other materials.)	
Total Amount	

The above amounts are in agreement with the Contractor's official accounting records. Documentation files of individual employee time reports and other expenditures are on file documenting all Contractor local match funds for maternal and child health efforts.

_____ _____

Name of Authorized Official: Financial Office or Director *Date*

* **NOTE**: A fixed amount of match is not required, rather a record of local support toward MCH issues is requested.

Appendix H Reporting Forms/Format *(Continued)*

FFY 2005 MCH Year End Report

Progress on Short-term Outcomes

Contractor: _____ Report prepared by: _____

Instructions: Describe below the progress in your work plan for the contract period. For each short-term outcome, describe the following: 1.) The data to verify the short-term outcome was met, and describe your progress toward achieving the outcome, 2.) If outcomes were not achieved, indicate the reasons and future plans to achieve the outcomes, and 3.) Areas where short-term outcomes were exceeded. Submit report by e-mail to both MCH District Team members and to *Department of Health and Senior Services, Healthy Communities and Schools Unit, MCH Program Manager.*

1. *(Enter Capacity-building Outcome for System Development)*
   a.) Progress toward achieving the short-term outcome. *(What were the FY05 results? List the data/information results for the outcome evaluation.)*
   b.) If outcome was not achieved, indicate the reasons and future plans to achieve the outcome.
   c.) Areas where outcome was exceeded.
2. *(Enter Short-term Outcome #1)*
   b.) Progress toward achieving the short-term outcome. *(What were the FY05 results? List the data results for the outcome evaluation.)*
   b.) If outcome was not achieved, indicate the reasons and future plans to achieve the outcome.
   c.) Areas where outcome was exceeded.
3. (*Enter Short-term Outcome #2)*
   a.) Progress toward achieving the short-term outcome. *(What were the FY05 results? List the data results for the outcome evaluation.)*
   b.) If outcome was not achieved, indicate the reasons and future plans to achieve the outcome.
   c.) Areas where outcome was exceeded.
4. (*Enter Short-term Outcome #3)*
   a.) Progress toward achieving the short-term outcome. *(What were the FY05 results? List the data results for the outcome evaluation.)*
   b.) If outcome was not achieved, indicate the reasons and future plans to achieve the outcome.
   c.) Areas where outcome was exceeded.
5. (*Enter Short-term Outcome #4)*
   a.) Progress toward achieving the short-term outcome. *(What were the FY05 results? List the data results for the outcome evaluation.)*
   b.) If outcome was not achieved, indicate the reasons and future plans to achieve the outcome.
   c.) Areas where outcome was exceeded.

Appendix I

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

VENDOR REQUEST FOR PAYMENT

VENDOR USE		
VENDOR NAME		INVOICE NUMBER
VENDOR REMIT TO ADDRESS		
STATE VENDOR NUMBER	BILLING PERIOD	
CONTRACT NAME / SERVICE	CONTRACT NUMBER	AMOUNT REQUESTED
COMMENTS		
I CERTIFY THAT THIS REPORT IS TRUE AND THAT ALL PAYMENTS CLAIMED ARE IN ACCORDANCE WITH THE PROVISIONS SET FORTH IN THE CONTRACT.		
AUTHORIZED SIGNATURE ►	TITLE	DATE

FOR DHSS PROGRAM USE ONLY		
PURCHASE ORDER (SC, SCS DOCUMENT NUMBER)	RECEIVER DOCUMENT (RC) NUMBER	
PROGRAM / BUREAU APPROVAL SIGNATURE(S)	TITLE	DATE APPROVED
COMMENTS		

ACCOUNTING DISTRIBUTION			DATE STAMP, ETC.
SC, SCS ACCOUNTING LINE NO.	AMOUNT	PLEASE CIRCLE ONE PARTIAL (P) FINAL (F)	
		P F	
		P F	
		P F	
		P F	
		P F	
APPROVED PAYMENT AMOUNT			

ACCOUNTS PAYABLE SIGNATURE ►	DATE PROCESSED

Appendix J

Glossary

1. **Assured Funds:** The portion of the contract award amount that the Contractor is guaranteed to receive. The part that is NOT dependent on performance of contract requirements. (See Provisional Funds.)
2. **Children**: A child from birth (0) through the 21st year, who is not otherwise included in any other class of individuals.
3. **Children with special health care needs**: All children with chronic conditions who require more than routine health care. The federal Maternal and Child Health Bureau's (MCHB) definition is as follows: "Children with special health care needs are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who require health and related services at a type or amount beyond that required by children generally."

   This is not limited to those who would meet the Department of Health and Senior Services, Bureau of Special Health CareNeeds program eligibility criteria.

   Examples using the broad federal MCHB definition: Children who have or are suspected of having the following conditions:

   a. chronic otitis media;
   b. behavioral problems such as Attention Deficit Disorder (ADD);
   c. learning disabilities;
   d. delayed speech development;
   e. age inappropriate height for weight;
   f. chronic infections;
   g. asthma ;
   h. heart defects or conditions;
   i. scoliosis;
   j. diabetes;
   k. seizures;
   l. genetic conditions; and/or
   m. other conditions which require health and related services at a type and amount beyond that required by children generally.

3. **Community Partners:** A person, in an agency or other entity outside your direct control, upon whom you rely to build and sustain your service coordination system.
4. **Community-focused Intervention***:* The coordination functions performed to assure that preventive interventions and services are available for the entire MCH population of the jurisdiction. Interventions are focused to changing community norms, community attitudes, community awareness, community practices, and community behaviors. Interventions may be directed at the entire population in a community or sometimes toward target groups within the population.
5. **Deaths to Children Aged 1-14 Caused by Motor Vehicle Crashes**: Includes occupant, pedestrian, motorcycle, bicycle and related deaths caused by motor vehicles.
6. **Inadequate Birth Spacing:** Live births occurring to females who had a prior live birth within eighteen months.

Appendix I Glossary *(Continued)*

7. **Inadequate Prenatal Care:** Fewer than five prenatal visits for pregnancies less than 37 weeks, fewer than eight visits for pregnancies 37 weeks or longer, or care beginning after the first four months of pregnancy.
9. **Incentive Award:** Additional funds a Contractor may receive based on positive change in Performance Measure Targets.
10. **Incentive Fund:** The pool of MCH funds, comprised of funds allocated for, but unused by a jurisdiction, and any prior year provisional funds withheld for non-performance of contract requirements.
11. **Individual-focused intervention:** The coordination of needed services when working with an individual or family. Interventions that work to change the knowledge, attitudes, beliefs, practices, skills and behaviors of individuals. Interventions that work to change the knowledge, attitudes, beliefs, practices, skills and behaviors of individuals.
12. **Infants:** Children under one year of age not included in any other class of individuals.
13. **Intervention:** Actions taken on behalf of individuals, families, systems, and communities to improve or protect health status.
14. **Long-term Outcome:** Long term accomplishments to effect changes in population health status and/or the department's strategic objectives addressed by the contract. Improvement in the performance measure targets is the ultimate outcome.
15. **Medical home:** Primary health care that is: accessible, continuous, comprehensive, family centered, and coordinated and is directed by an appropriately trained and licensed health care professional.
16. **Milestone:** The critical steps that must be achieved to ensure that a project is on course to achieve the short-term outcomes.
17. **Outcome:** Benefits for participants or public following performance of work in a contract.
18. **Outcome Measurement:** The assessment of the results of a program compared to its intended purpose.
19. **Over weight Child:** A child whose weight is at or above the 95th percentile.
20. **Performance Measure:** The specific item of information that tracks the contractor's success/effectiveness in completing the services described in the scope of work. A statement of a requirement that, when successfully addressed, will lead to an improved health status indicator and/or the department's strategic objectives addressed by the contract.
21. **Performance Measure Target:** The annual objective for improvement in a health status indicator.
22. **Pregnant Woman:** A female from the time she conceives to 60 days after birth, delivery, or expulsion of fetus
23. **Provisional Funds:** The non-assured portion of a Contractor's award amount that may be retained by the Contractor based on full performance of contract requirements.
24. **Preventive services:** Activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Appendix I Glossary *(Continued)*

25. **Service Coordination:** A collaborative process that addresses the health needs of a population through identification, assessment, referral, assurance, education and evaluation, using communications and available resources to promote quality and improved outcomes.
26. **Short-term Outcome:** For the MCH contract this means annual measures of change that make the system work better. The specific result that a contractor will commit to achieve within the contract period. Attainment can be verified through documentation provided by the contractor at the end of the contract year.
27. **Supplanting:** Utilizing funds from this contract to fund activities that are currently being funded from another source. However, the funding from this contract may be used to increase or expand activities funded by other sources.
28. **System:** A perceived whole whose elements "hang together" because they continually affect each other over time and operate toward a common purpose.
29. **System-focused Intervention***:* Activities directed at improving and maintaining the health status of all women and children by providing support for infrastructure development and maintenance of comprehensive health systems. Interventions that work to change organizations, policies, laws, and power structures. There is less of a focus on the individuals and community, and more focus on the systems that impact health.
30. **Target Population/Program Participant:** People or entities that directly interact with an organization's interventions and service coordination system. This interaction is intended to result in a change in the participants' behavior or condition in line with short-term outcomes and mission.
31. **Uninsured:** Children without public or private insurance policies.
32. **Verification:** Establishing that something represented to happen, does in fact take place. Verification typically focuses on milestone and short-term outcome accomplishments.

Section 4: Scope of Work for MCH Contract

SCOPE OF WORK

MATERNAL CHILD HEALTH - TITLE V CONTRACT

October 1, 2004 - September 30, 2005

1.0 Purpose

1.1 To establish an integrated multi-tiered service coordination system (individual, community and system) capable of adapting to address targeted maternal-child health issues.

2.0 Deliverables

2.1 The Contractor shall execute the approved plan of work (Exhibit 1).

2.2 The Contractor shall comply with all terms and conditions set forth in the Program Guidance for FFY 2005 Maternal and Child Health (MCH) contracts, to include develop and implement a written plan for continuous quality improvement.

3.0 Reports

3.1 The Contractor shall submit reports using the forms and/or formats specified by the Department.

3.1.1 The Contractor shall report quarterly on

3.1.1.1 Progress toward milestone outcomes in the plan of work.

3.1.1.2 Total cost incurred in meeting the outcomes in the plan of work.

3.1.1.3 Cash match from any non-federal source, and must clearly document use of those funds for maternal and child health

3.1.2 The Contractor shall report annually on progress toward short-term outcomes in the plan of work.

3.2 Quarterly reports shall be received by the last day of the months of January, April, July, and October.

3.3 The annual report for the contract year shall be received by thirty (30) days following the end of the contract period (October 30th).

4.0 Invoicing and Payments

4.1 The Contractor shall submit to the Department uniquely identifiable invoices for payment processing using the Vendor Request For Payment (DH-38). Uniquely identifiable means the particular invoice or bill can be distinguished by invoice number from a previously submitted invoice.

4.2 The Contractor shall invoice the Department for one-twelfth of the total award amount by the last day of the month following each contract month.

4.3 The Department shall have no obligation to pay any invoice submitted after the due date.

4.4 The Contractor shall follow the MCH Outcome Funding Plan for FFY 2005 and any successive contract years as described in the Program Guidance for Maternal and Child Health contracts

4.4.1 The Contractor shall complete all annual short-term outcomes in order to retain all provisional funds as defined in the Program Guidance for FFY 2005 Maternal and Child Health contracts.

4.4.2 The Department shall reduce funding based on the negotiated condition for each short-term outcome not completed by the Contractor.

4.4.2.1 The negotiated condition for each short-term outcome shall be no lower than five (5) percent of provisional funds.

4.4.2.2 The Contractor may choose to have the reduction made from the award amount for the following contract year or may choose to issue a check for the difference made payable to ”DHSS-DOA-Fee Receipts” and shall mail the payment to:

Missouri Department of Health and Senior Services
Division of Administration
Fee Receipts
PO Box 570
920 Wildwood Drive
Jefferson City, MO 65102-0570

4.4.2.3 In the event the Contractor does not participate in the following year, the Contractor will issue a check for the difference made payable to ”DHSS-DOA-Fee Receipts” and shall mail the payment to:

Missouri Department of Health and Senior Services
Division of Administration
Fee Receipts
PO Box 570
920 Wildwood Drive
Jefferson City, MO 65102-0570

4.5 The Contractor shall be eligible for an Incentive Award after participation in the contract for three (3) successive years based on the following conditions:

4.5.1 The Contractor’s Performance Measure Targets shall not have changed during the previous three (3) years.

4.5.2 The Contractor shall meet or exceed the Performance Measure Targets.

4.5.3 Award of incentive funds will be based on availability of funds available to the Department.

4.6 If the Contractor is overpaid by the Department, the Contractor will issue a check made payable to ”DHSS-DOA-Fee Receipts” and shall mail the payment to:

Missouri Department of Health and Senior Services
Division of Administration
Fee Receipts
PO Box 570
920 Wildwood Drive
Jefferson City, MO 65102-0570

4.7 If a request by the Contractor for payment is denied, the Department shall provide the Contractor with written notice of the reason(s) for denial.

5.0 Monitoring

5.1 The Department reserves the right to monitor this contract through on-site visits during the contract period at a minimum of once a year to ensure contractual compliance.

5.2 The Department reserves the right to request an audit performed in accordance with generally accepted auditing standards at the expense of the Contractor at any time contract monitoring reveals such audit is warranted.

6.0 Special Provisions

6.1 To the extent that funds are appropriated and available, the Department shall have the right, at its sole option, based upon available funding and Contractor performance, to renew the contract for two (2) additional one-year periods.

6.2 The Contractor shall attend two professional development offerings provided by the Department Maternal and Child Health program during the contract period.

6.3 The Contractor may request to amend the approved plan of work during the contract year by submitting, on agency letterhead, the reason for the requested change(s), and the revised plan.

6.3.1 The Contractor shall submit amendment requests six (6) months prior to the expiration of the contract.

6.3.2 The Contractor may substitute short-term outcomes in the amended plan of work that are of equal value to the original short-term outcomes.

6.3.3 Requested amendments may be approved, modified, or rejected by the Department in accordance with the MCH Program Guidance.

6.4 The Contractor agrees that funds provided by the Department may not be used in any manner to replace or supplant state or federal funds for any service included in this contract. Funds shall be used to expand or enhance MCH activities. For payments under this contract, the Department shall be viewed as the payer of last resort.

6.5 Funding under this contract shall not be expended for the purpose of performing, assisting, or encouraging abortion, and none of these funds shall be expended to directly, or indirectly, subsidize abortion services.

6.6 Funding under this contract shall not be expended for the purpose of providing comprehensive family planning services.

6.7 Individuals with income falling below one hundred percent (100%) of the federal poverty guidelines shall not be charged for services under this contract. Poverty guidelines are published annually by the U. S. Department of Health and Human Services.

6.8 The Department reserves the right to unilaterally approve changes on any Department-supplied contract reporting forms and formats.

6.9 The Contractor may subcontract for the provision of services as described in this contract, provided that any subcontract include appropriate provisions and contractual obligations to ensure the successful fulfillment of all contractual obligations agreed to by the Contractor and the Department, including the civil rights requirements set forth in 19 CSR 10-2.010(5)(A)-(L), and provided that the Department approves the subcontracting arrangement prior to finalization. The Contractor shall ensure that the Department is indemnified, saved and held harmless from and against any and all claims of damage, loss, and cost (including attorneys fees) of any kind related to a subcontract in those matters described herein.

6.9.1 The Contractor shall expressly understand and agree that the responsibility for all legal and financial obligations related to the execution of a subcontract rests

solely with the Contractor; and the Contractor shall assure and maintain documentation that any and all subcontractors comply with all requirements of this contract. The Contractor shall agree and understand that utilization of a subcontractor to provide any of the equipment or services in this contract shall in no way relieve the Contractor of the responsibility for providing the equipment or services as described and set forth herein.

6.10 The Contractor shall be responsible for assuring that all personnel including those of any subcontractor(s), are appropriately licensed or certified, as required by state, federal or local law, statute or regulation, respective to the services to be provided through this contract; and documentation of such licensure or certification shall be made available upon request.

6.11 The Contractor shall be responsible for all claims, actions, liability, and loss (including court costs and attorney's fees) for any and all injury or damage (including death) occurring as a result of the Contractor's performance, or the performance of any subcontractor, involving any equipment used or service provided, under the terms and conditions of this contract or any subcontract, or any condition created thereby, or based upon any violation of any state or federal statute, ordinance, building code, or regulation by Contractor. However, the Contractor shall not be responsible for any injury or damage occurring as a result of any negligent act or omission committed by the State, including its agencies, employees, and assigns.

6.12 The Contractor assumes liability for all disclosures of confidential information by the Contractor and/or the Contractor's subcontractors and employees. The Contractor agrees to comply with all applicable provisions of the Federal Standards for Privacy of Individually Identifiable Health Information (45 C.F.R. Parts 160 and 164). The Contractor acknowledges that pursuant to these regulations, it is a business associate of the Division of Community Health.

6.13 If State and/or Federal funds are not appropriated, continued, or available at a sufficient level, or in the event of a change in Federal or State law relevant to this contract, the obligations of each party may, at the sole discretion of the Department, be terminated in whole or in part, effective immediately or as determined by the Department, upon date of certified mailing, facsimile, or e-mail of written notice to the Contractor by the Department.

6.14 This contract shall be governed by and construed in accordance with the laws of the State of Missouri. The Contractor shall comply with all federal and state laws applicable to this contract including but not limited to those laws authorizing or governing the use of federal funds paid to the Contractor through this contract.

6.15 Return of the proposed contract within forty-five (45) calendar days of the date mailed by the Department is necessary to ensure execution of this contract by the Department.